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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445047	A. BUILDING _____ B. WING _____	02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GARDENS HEALTH AND REHABILITATION	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the recertification survey and complaint investigation (#00029279), conducted on February 12-14, 2012, at Imperial Gardens Health and Rehabilitation, no deficiencies were cited under 42 CFR PART 483.13, Requirements for Long Term Care for the complaint.	F 000	This Plan of Correction affirms our allegation of compliance for the deficiencies cited, however, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to ensure call lights where answered timely for three residents (#1, #23, #24) of twenty-five residents reviewed. The findings included: Resident #1 was admitted to the facility on January 9, 2012, with diagnoses including Pneumonia, Muscle Weakness, Chronic Kidney Disease, Dysphagia, and Edema. Review of the Minimum Data Set, (MDS) dated January 16, 2012 revealed the resident to be cognitively intact, and requiring assistance with	F 246	Resident #1 was immediately assessed per nursing staff for any physical/mental injury, with no issues identified. Resident request was identified and completed. Residents #23 and #24 were immediately assessed by nursing staff and the needs of the residents were addressed. All facility residents have the potential to be affected and can benefit from corrective action.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Boss — TITLE: Administrator — (X6) DATE: 3-15-12

For deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J2KC11 Facility ID: TN1912 If continuation sheet Page 1 of 15

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F 246	Continued From page 1 activities of daily living, ambulation, toileting, and transfers. Interview with the resident on February 12, 2012, at 10:32 A.M., in the resident's room, during initial tour revealed, the resident reported a fall "last week" that "caused me to lay in the bathroom a long time". Interview with Certified Nurse Technician (CNT) #2, on February 12, 2012, at 10:45 A.M., in the 400 Wing Hallway, confirmed on February 6, 2012 the resident was found on the floor of the resident's bathroom by CNT #2. Continued interview revealed, upon arrival to the unit at approximately 7:00 A.M., CNT#2 was not able to see, or locate other staff members on the unit and began answering call lights that were activated, and noticed Resident #1's bathroom call light was activated. Further interview revealed CNT #2 arrived in the resident's room at 7:15 A.M. and found the resident lying on the floor; at which time the CNT summoned a nurse to the room, and removed the resident from the floor at 7:20 A.M. with the assistance of the nurse. The resident was not injured. Review of facility documents "Statement Form" revealed, ..." when I came in around 7, I seen a lot of call lights going off .... Went to see about.. bath" (emergency light) "...cause it was red when I came in... (resident on) bathroom floor...left side ... no tecs reported to me ..." Continued review of the facility's document "call light audit" (electronic monitoring tool of call light activation and response times) revealed, "... cleared alarms 1 (number of alarms responded to	F 246	On 2/22/12, 2/23/12, 2/27/12, 2/28/12, 3/2/12, and 3/5/12 an all staff meeting will be conducted by the Director of Nursing to in-service the staff on the facility expectation that all staff answer call light requests within at least a 3 minute time frame. The Director of Nursing (DON) and/or designee will assign a member of the management team to conduct call light drills consisting of at least 2 per shift and a minimal of 5 times per week. This will continue for six weeks, then randomly for at least two months . Call light drills will consist of a manager entering a room putting on the call light and timing staff response. The answer time will be recorded on the call light drill form.	

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F 246	Continued From page 2 equaled one) "... total time 19.3 minutes ... AVE (Average) 19.3 min...2/6/2012 7:09:58 AM (time alarm was activated) ...7:29:14 AM (time alarm was turned off)...LOC... (location resident #4's room) BATH...Rtime (run time)19:30. (nineteen minutes thirty seconds)" Continued review of the facility's documentation revealed, " ... I spoke with ... again ...upon her arrival at 6:50 am ... stated there was no one present and ... began answering call lights as soon as ... came onto the floor... found patient had fallen in the bathroom floor ...the patient told ...been in floor ..."a long time"... IDON (Interim Director of Nursing)" Interview with the Assistant Director of Nursing (ADON) on February 12, 2012, at 3:40 P.M., in the ADON's office, confirmed the resident was not injured during the fall and the resident was on the bathroom floor for "nearly 20 minutes" Interview with the ADON on February 13, 2012, at 8:00 A.M., in the ADON's office, confirmed bathroom call lights are considered emergency call lights and were to be answered immediately. Continued interview confirmed the bathroom call light was activated by use of an emergency pull cord, the nineteen minute thirty second delayed response to the call light on February 6, 2012 was not timely. Resident #23 was admitted to the facility with diagnoses including Emphysema, Anemia, and History of Falls. Medical record review of the Minimum Data Set (MDS) dated December 1, 2011, revealed the	F 246	Results of the call light drills will be presented by the Director of Nursing or her designee to the clinical meetings, and aggregated to define any trends and presented by the Director of Nursing or her designee to the Quality Assurance committee monthly for continued monitoring and improvements.	3/30/12

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F 246	Continued From page 3 resident was always understood and was always able to make needs known. Continued review of the Brief Interview for Mental Status (BIMS) revealed a score of 15 indicating cognitively intact. Observation on the 200 hall on February 13, 2012, at 5:15 a.m., revealed resident #23's call light was activated. Continued observation revealed the call light was not answered until 5:28 a.m. (a thirteen minute delay). Resident #24 was admitted to the facility with diagnoses including Legal Blindness, Congestive Heart Failure, and Lower Limb Amputation. Medical record review of the MDS dated January 19, 2012, revealed the resident was always understood and was always able to make needs known. Continued review of the BIMS revealed a score of 15 indicating cognitively intact. Observation on the 200 hall on February 13, 2012, at 5:22 a.m., revealed resident #24's call light was activated. Continued observation revealed the call light was not answered until 5:27 a.m. (a five minute delay). Interview with the Charge Nurse present on the 200 hall, on February 13, 2012, at 5:28 a.m., confirmed the call lights were not answered timely. Interview with the Interim Director of Nursing on February 14, 2012, at 8:40 a.m., in the Director's office, confirmed that call lights are to be answered within three minutes.	F 246		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 4 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to provide a splint for one resident (#12) of twenty-five residents reviewed. The findings included: Resident #12 was readmitted to the facility on August 24, 2011, with diagnoses including Hypertension, Aftercare of Knee Surgery, and Cardiac Dysrhthmias. Review of the physician's progress notes dated November 25, 2011, revealed "...has been having numbness and decreased sensation in the left hand ...also some diminished strength in the hand ...assessment: 1. Probable carpal tunnel left hand. Plan: Trial of wearing a splint on the left wrist at night." Review of the physician's order dated November 25, 2011, revealed splint to left wrist, to be applied at HS (night) continuous use. Review of the resident's care plan updated	F 318	F318 Resident #12 was re-assessed by the therapy department for evaluation of the benefits of the splint. It was determined the splint would not be beneficial for the resident and the order for the splint was discontinued after the recommendations were reviewed with the Physician. All residents with orders for splints and/or special devices have potential to be affected and can benefit from corrective action. All residents with orders for splints will be audited by the nurse supervisor weekly to ensure proper supportive equipment is ordered and being utilized per application protocol and times. These audits will occur weekly until 3/30/12 and then and then monthly.	

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F 318	Continued From page 5 January 15, 2012, revealed ...splint left wrist apply q (every) HS (night) and remove q am per orders. Interview with registered nurse #1 (RN) on February 13, 2012, at 6:00 a.m., in the hallway, verified the resident was to have a splint in place. Observation and interview with resident #12 on February 13, 2012, at 6:04 a.m., revealed no splint was on and the resident stated had never had a splint for the wrist. Interview with the Interim Director of Nursing (DON) on February 13, 2012, at 2:15 p.m., in the DON's office, confirmed the resident did not have a splint for the left wrist and revealed the splint had never been ordered.	F 318	All new orders from the previous 24 hour report will be reviewed daily during the clinical meeting (which includes the nurse supervisor, MDS nurse, Therapy manager, Social Worker, Dietary Manager, Activity Director, and the DON). All orders involving splints and/or special devices will be referred by the nurse supervisor to the therapy department for evaluation and treatment recommendations. All issues identified will be presented by the DON or her designee at the At Risk meeting weekly for any interdisciplinary recommendations and interventions. All results will be collected and presented by the DON or her designee to the Quality Assurance committee monthly for continued monitoring and improvement.	3/30/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide supervision to prevent falls, for one resident (#1)	F 323		

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F 323	Continued From page 6 failed to secure prescribed chemicals and pharmaceuticals for one resident (#4) of twenty-five residents reviewed. The findings included: Resident #1 was admitted to the facility on January 9, 2012, with diagnoses including Pneumonia, Muscle Weakness, Chronic Kidney Disease, Dysphagia, and Edema. Review of the Minimum Data Set, (MDS) dated January 16, 2012 revealed the resident to be cognitively intact, and requiring assistance with activities of daily living, ambulation, toileting, and transfers. Interview with the resident on February 12, 2012, at 10:32 A.M., in the resident's room, during initial tour revealed, the resident reported a fall "last week" that "caused me to lay in the bathroom a long time". Interview with Certified Nurse Technician (CNT) #2, on February 12, 2012, at 10:45 A.M., in the 400 Wing Hallway, confirmed on February 6, 2012 the resident was found on the floor of the resident's bathroom by CNT #2. Continued interview revealed, upon arrival to the unit at approximately 7:00 A.M., CNT#2 was not able to see, or locate other staff members on the unit and began answering call lights that were activated, and noticed Resident #1's bathroom call light was activated. Further interview revealed CNT #2 arrived in the resident's room at 7:15 A.M. and found the resident lying on the floor; at which time the CNT summoned a nurse to the room, and removed the resident from the	F 323	F323 Resident #1 was immediately assessed per nursing staff for any physical/mental injury, with no issues identified. Fall interventions were initiated at that time. Resident #4's room was inspected for any potential hazards. Supplies for the wound care were properly labeled and placed in a plastic bag and stored in the resident's closest shelf. All residents have the potential to be affected and can benefit from corrective action. On 3/2/12 and 3/5/12 a staff meeting will be conducted by the Director of Nursing to in-service the staff on the facility policy and procedure of safe storage of resident's personal items and supplies. Staff were inserviced on 2/22, 2/23, 3/5, and 3/7/2012 by the DON on the requirement that the facility must provide a safe, functional, sanitary environment for the residents.	

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F 323	Continued From page 7 floor at 7:20 A.M. with the assistance of the nurse. The resident was not injured. Review of facility documents "Statement Form" revealed, ..." when I came in around 7, I seen a lot of call lights going off .... Went to see about.. bath" (emergency light) "...cause it was red when I came in... (resident on) bathroom floor...left side ... no tecs reported to me ..." Continued review of the facility's document "call light audit" (electronic monitoring tool of call light activation and response times) revealed, "... cleared alarms 1 (number of alarms responded to equaled one) "... total time 19.3 minutes ... AVE (Average) 19.3 min...2/6/2012 7:09:58 AM (time alarm was activated) ...7:20:14 AM (time alarm was turned off)...LOC... (location resident #4's room) BATH...Rtime (run time)19:30. (nineteen minutes thirty seconds)" Continued review of the facility's documentation, revealed, " ... I spoke with ... again ...upon her arrival at 6:50 am ... stated there was no one present and ... began answering call lights as soon as ... came onto the floor... found patient had fallen in the bathroom floor ...the patient told ...been in floor ..."a long time"... IDON (Interim Director of Nursing)" Interview with the Assistant Director of Nursing (ADON) on February 12, 2012, at 3:40 P.M., in the ADON's office, confirmed the resident was not injured during the fall and the resident was on the bathroom floor for "nearly 20 minutes" Interview with the ADON on February 13, 2012, at 8:00 A.M., in the ADON's office, confirmed	F 323	The DON and/or designee will conduct room audits of at least 10 rooms, 5 times per week for six weeks to ensure all supplies and personal items are properly labeled and stored in a safe manner. Any issues identified will be corrected at that time and recorded on a room audit form. The room audit forms will be aggregated and presented monthly by the Director of Nursing to the Quality Assurance committee to identify trends for recommendations and continue monitoring.	3/30/12

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F 323	Continued From page 8 bathroom call lights are considered emergency call lights and were to be answered immediately. Continued interview confirmed the bathroom call light was activated by use of an emergency pull cord, the nineteen minute thirty second delayed response to the call light on February 6, 2012 was not timely. Resident #4 was admitted to the facility August 17, 2011, with diagnoses including Closed Fracture of the Clavicle, Pressure Ulcer, Congestive Heart Failure, General Osteoarthritis, and Coronary Artery Disease. Medical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident had severe cognitive impairment, was bedbound, and required total assistance with all activities of daily living. Observation on February 12, 2012, at 10:30 a.m., in the resident's room, revealed the resident was in contact isolation. Further observation revealed sealed dressing supplies, a bottle of Betadine, and a bottle of Dakin's Solution 0.125%, prescribed to the resident, on the overbed table. Interview with LPN #1, at 10:35 a.m., in the resident's room, confirmed the dressing supplies and prescribed wound treatments were not to be in the room and should have been secured in the treatment cart.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 9 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and facility policy review, the facility failed to maintain infection control standards for	F 441	F441 On 2/14/12 wound care for resident #22 was completed following facility policy and procedure and CDC guidelines. All residents requiring wound care treatment have potential to be affected and can benefit from corrective action. On 2/22/12, 2/23/12, 3/5/12, 3/7/12, and 3/9/12 a mandatory in-services will be conducted by the Director of Nursing to educate all nursing staff on the facility wound care policy and procedure with focus on CDC infection control practices. A clinical skills check-off will be completed on all nursing staff providing wound care for competency using return demonstration by the Director of Nursing for six weeks. The DON and/or designee will conduct wound care compliance rounds on at least three wound care dressing changes per week for six weeks.	

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F 441	Continued From page 10 one resident (#22) during a dressing change. The findings included: Resident #22 was admitted to the facility on January 6, 2011, with diagnoses including Muscle Weakness, Urinary Tract Infection (UTI), Hypotension and Leukocytosis (elevated white blood cell count). Medical record review a physicians order sheet, dated January 20, 2011, revealed "...cleanse wound on left heel, left fifth toe and left ankle with wound cleanser: apply "restore" silver or Silvadene dressing to left heel, left fifth toe and left ankle (cut silver to size). Cover with 4x4 and then cover with Kerlex... " Observation on February 13, 2012, at 2:20 p.m., in the resident's room, revealed Registered Nurse (RN) #2 changed the resident's dressings to the left 5th toe, the left ankle and heel. Observation revealed the nurse sanitized the hands with a waterless hand sanitizing solution, donned gloves to the hands and removed the dressings using scissors from the nurses pocket. Continued observation revealed the nurse turned around and retrieved the dirty trash can, brought the trash can to the bedside using the same contaminated gloves without sanitizing the hands or changing the gloves, and measured each wound. Further observation revealed RN #2, without changing the gloves or sanitizing the hands, cleaned the wounds using wound cleanser and a sterile applicator, discarded the old dressing and the applicator in the trash can and failed to	F 441	The DON and/or designee will present the information obtained from the wound care observation rounds to the Quality Assurance committee monthly for recommendations on any trends and continuous monitoring.	3/30/12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11	F 441		

remove the contaminated gloves or wash the hands. Further observation revealed the nurse wiped sweat from own forehead with the contaminated gloves.

Continued observation revealed the nurse, without sanitizing the hands or changing gloves, opened a pack of 4x4's, removed the cap from the Silvadene (ointment medication used for wound healing), and applied the ointment to the wounds without changing the gloves or sanitizing the hands. Observation revealed, without sanitizing the hands or changing the gloves, the nurse applied 4x4 ' s to each wound and wrapped the wounds with Kerlex. Continued observation revealed the nurse removed the soiled gloves, washed the hands with a waterless hand sanitizing solution, exited the room, and placed the used contaminated 4x4's and wound cleanser in the medication cart outside of the room.

Interview with RN #2, on February 13, 2012, at 2:30 p.m., in the hallway outside the resident's room, confirmed the nurse failed to wash the hands or change the contaminated gloves during the dressing change. Further interview with the nurse confirmed the contaminated cleaning supplies were removed from resident #22's room and placed in the medication cart for continued use on other residents.

Review of facility policy, Wound Care Procedure for Major Wounds, with a revision date of 2010, revealed "...set up supplies on a clean surface at the bedside...wash your hands...put gloves on...remove the soiled dressing and place in a bag at the bedside...remove gloves ...wash your hands...put on gloves...clean the wound...remove

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445047	A. BUILDING _____ B. WING _____	02/14/2012

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F 441	Continued From page 12 gloves and place in bag...put on new gloves...apply clean dressing as ordered...remove gloves and place in bag...wash your hands..." Interview with the Interium Director of Nursing (IDON), on February 13, 2012, at 2:40 p.m., in the DON's office, confirmed that facility policy was not followed for a dressing change and infection control standards were not followed.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to maintain a sanitary environment in the resident's room for one resident (#25) of twenty five residents reviewed. The findings included: Resident # 25 was admitted to the facility on September 30, 2009, with diagnoses including Anemia, Dementia, Senile Dementia, Visual Loss and Diabetes Mellitus, type 2. Observation and interview at 10:15 a.m., during the initial tour of the facility, on February 12, 2012, revealed resident #25 in the room with family at the bedside. Observation and interview with the resident's family member revealed in the	F 465	F465 Resident #25's room was cleaned and sanitized by the housekeeping staff. All facility residents have potential to be affected and can benefit by the corrective action. The DON will assign a management team member to conduct room rounds of at least 10 rooms per day for a minimal of 5 days per week for six weeks, with a focus on the cleanliness and sanitary condition of the resident's environment. Staff was inserviced 2/22/12, 2/23/12, 3/5/12, and 3/7/12 by the Director of Nursing on the requirement that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 465	Continued From page 13 resident's bathroom, brown colored debris was on the floor around the commode and the doorway of the bathroom. Further interview with the family member revealed "this is not uncommon". Further observation revealed the brown colored debris around the resident's recliner where the resident was seated. Interview with Licensed Practical Nurse (LPN) #1, on February 12, 2012, at 10:25 a.m., in the resident's room and bathroom, confirmed the brown colored debris in the bathroom and beside the resident's recliner and the environment was not clean.	F 465	Information collected from the results of the room rounds will be presented by the DON or her designee and discussed in the stand up meetings All information will be collected and submitted by the DON or her designee to the Quality Assurance committee monthly for recommendations and continued monitoring.	3/30/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to document a fall for one resident (#1) of twenty-five residents reviewed.	F 514	F514 On 3/1/12 a complete record review was completed on Resident #1's medical record by the DON. A late entry documentation for the fall on 2/6/12 was entered into the record with information obtained off the incident investigation dated 2/16/12. All facility residents have potential to be affected and	

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F 514	Continued From page 14 The findings included: Resident #1 was admitted to the facility on January 9, 2012, with diagnoses including Pneumonia, Muscle Weakness, Chronic Kidney Disease, Dysphagia, and Edema. Review of the Minimum Data Set, (MDS) dated January 16, 2012 revealed, the resident to be cognitively intact, and requiring assistance with activities of daily living, ambulation, toileting, and transfers. Review of the facility's documentation revealed resident #1 sustained a fall with no injury on February 6, 2012. Review of the facility medical records "Nurses Notes" revealed no documentation of the fall. Interview with the Interim Director of Nursing (IDON) on February 12, 2012, at 3:40 P.M., in the IDON's office confirmed the fall had occurred on February 6, 2012. Continued interview confirmed the facility had failed to document the fall.	F 514	can benefit from the corrective action. The prior days 24 hour report will be reviewed by the nurse supervisors in the clinical meeting (the clinical meeting members are the Director of Nursing, nursing supervisors, Social worker, Dietary manager, Activity Director and Therapy manager. Any falls, incidents, abnormal events for the prior day will be reviewed and discussed during the clinical meeting. The clinical record will be reviewed by the nursing supervisor to ensure all documentation regarding the event/incident is present and accurate in the medical record. Any issues identified in the clinical meeting will be documented and submitted by the Director of Nursing monthly to the Quality Assurance Committee for review, recommendations, and continued monitoring.	3/30/12